

EXHIBIT A

06/17/2009 WED 18:55 FAX 1 808 524 4591 Alston Hunt Floyd & Ing

002/003

DECLARATION OF C. MICHAEL MOORE

I, C. Michael Moore, declare:

1. I am an attorney admitted to practice *pro hac vice* before this Court and am one of the attorneys representing Defendants Schering Corporation, Schering-Plough Corporation and Warrick Pharmaceuticals Corporation in these cases. In that capacity, I have personal knowledge of the facts stated in this Declaration, and I know these facts are true.

2. On Thursday, June 11, 2009, I spoke to Michael Wingate-Hernandez, one of the attorneys representing the State of Hawai'i, concerning the depositions scheduled for the week of June 22, 2009, in Hawai'i. Mr. Wingate-Hernandez was in Honolulu for the depositions scheduled for the week of June 8, 2009. He asked me if we should go forward with the deposition of Lynn Donovan on June 23, 2009. I told him the deposition must go forward that week because of the Court's trial schedule and because I was prepared to take the deposition and was already in Hawai'i. I also explained to him that I could not take the deposition in July 2009 due to prior commitments. I also said that we had, I believed, another Hawai'i Medicaid witness, Angie Payne, scheduled to come to Honolulu at Defendants' expense the week of June 22, 2009.

3. After discussing the situation, Mr. Wingate-Hernandez agreed the deposition of Ms. Donovan would go forward the week of June 22, 2009, but asked if we would move it to June 24, 2009, to facilitate his travel back to Honolulu. After checking with other defense counsel, we agreed to accommodate Mr. Wingate-Hernandez's schedule and agreed Ms. Donovan's deposition would proceed on June 24, 2009. In addition, based on subsequent e-mail communications with Rick Eichor, another attorney representing the State, the parties agreed Ms. Payne's deposition would take place in Honolulu on June 26, 2009.

4. I took the deposition of Ms. Donovan the first time she was deposed in this litigation, and I will be taking the lead again this time. I have spent a considerable amount of time preparing for her deposition and am currently in Hawai'i and planning to travel back to Honolulu on June 20, 2009, to make final preparations for the depositions of Ms. Donovan and

Jun 17 2009 22:54

KRAU WARRICK RESUR FAX: 808 274 5509

06/17/2009 WED 18:56 FAX 1 808 524 4591 Alston Hunt Floyd & Ing

003/003

Ms. Payne, I am not available to take these depositions on the dates in July proposed by the State's attorneys.

I declare under the penalty of perjury that the foregoing is true and correct. Executed on this 17th day of June, 2009, at Lihu'e, Hawai'i.


C. MICHAEL MOORE

EXHIBIT B



Beasley Allen

BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.
Attorneys at law

JERE LOCKE BEASLEY
J. GREG ALLEN
MICHAEL J. CROW
THOMAS J. METHVIN
J. COLE PORTIS
W. DANIEL MILES, III
R. GRAHAM ESDALE, JR.
JULIA ANNE BEASLEY
RHON E. JONES
LABARRON N. BOONE
ANDY D. BIRCHFIELD, JR.

RICHARD D. MORRISON
C. GIBSON VANCE
J. P. SAWYER
C. LANCE GOULD
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WILLIAM H. ROBERTSON, V
H. CLAY BARNETT, III
CHRISTOPHER D. BOUTWELL
J. PARKER MILLER
DANIELLE W. MASON
SOME ATTORNEYS ADMITTED IN:
AZ, AR, DC, FL, GA, KY, LA, MN, MS, MI,
NY, OH, OK, PA, SC, TN, TX, WV

June 17, 2009

Mr. Mike Moore
Sonnenschein Nath & Rosenthal LLP
2000 McKinney Avenue, Suite 1900
Dallas, TX 75201-1858

Re: *State of Hawaii v. Abbott Laboratories, Inc., et al.*
First Circuit Court, Civil No. 06-1-0720-04 EEH

Dear Mike:

As I explained to you yesterday via voicemail message and email, the State cannot go forward with the depositions of Lynn Donovan and Angie Payne as previously scheduled for next week. Unfortunately, counsel for the State has developed unavoidable conflicts which require that these depositions be rescheduled. As I suggested to you, we can make these witnesses available for deposition during the week of July 13, 2009. As you are aware, there are two hearings that week for which defense counsel will be present in Honolulu anyway. I understand that you may have conflicts in July. Accordingly, I am willing to work with you to reschedule these depositions at our mutual convenience.

I am notifying all counsel of the postponement of these depositions via Lexis Nexis.

Thank you for your time and cooperation. If you have any questions or comments, please do not hesitate to contact me.

EXHIBIT K

With kindest regards,

**BEASLEY, ALLEN, CROW,
METHVIN, PORTIS & MILES, P.C.**

A handwritten signature in black ink, appearing to read "Clinton C. Carter", with a stylized, flowing script.

CLINTON C. CARTER

CCC/mms

cc: All Counsel of Record via Lexis Nexis

EXHIBIT C

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CITIZENS FOR CONSUMER, et al . CIVIL ACTION NO. 01-12257-PBS
Plaintiffs .

V. . BOSTON, MASSACHUSETTS
. AUGUST 20, 2008

ABBOTT LABORATORIES, et al .
Defendants .

.

TRANSCRIPT OF MOTION HEARING
BEFORE THE HONORABLE MARIANNE B. BOWLER
UNITED STATES MAGISTRATE JUDGE

APPEARANCES:

For the United States: Ana Maria Martinez, Esquire
Justin Dracut, Esquire
United States Attorney's
Office
99 N.E. 4th Street
Miami, FL 33132
305-961-9000
Ana.Maria.Martinez@usdoj.gov

For Ven-A-Care: Ken Bresnick, Esquire

For Abbott Labs.: Jason Winchester, Esquire
Jones Day
77 West Wacker Drive
Chicago, IL 60601-1692
312-782-3939

For Schering: Kim Nemirow, Esquire
John T. Montgomery, Esquire
Ropes & Gray LLP
One International Place
Boston, MA 02110
617-951-7565
jmontgomery@ropesgray.com

For the City of New York and

MARYANN V. YOUNG
Certified Court Transcriber
Wrentham, MA 02093
(508) 384-2003

1 MS. CICALA: This involves us as well, Your Honor.
2 Should we - what perhaps--

3 THE COURT: All right, what about 5296?

4 MR. MONTGOMERY: That's a motion for a protective
5 order, Your Honor. I'm arguing that as well and--

6 MS. CICALA: We're involved in--

7 THE COURT: Okay. Well let's--

8 MR. MONTGOMERY: But perhaps--

9 MS. CICALA: May I may a suggestion.

10 MR. MONTGOMERY: Maybe we--

11 THE COURT: Do we have other team members?

12 MR. MONTGOMERY: Yeah. If they have other staff I'll
13 confer and they can continue.

14 THE COURT: All right, fine.

15 MS. ASNIS: I believe, Your Honor, though that a
16 representative of the counties is necessary for this meet and
17 confer for purposes of the stipulations that may or may not be
18 required are satisfactory.

19 MS. CICALA: I agree. Aaron Hovan can participate.
20 I--

21 THE COURT: Okay, we'll take a 20 minute break. I'll
22 be back at 12:20.

23 MS. CICALA: Thank you, Your Honor.

24 MS. ASNIS: Thank you, Your Honor.

25 MR. MONTGOMERY: Thank you.

1 RECESS

2 THE COURT: Do we have a report?

3 MR. MONTGOMERY: Your Honor, we conferred as you
4 suggested and subject to correction let me try to state where I
5 think we came out. First, that it will be assumed or presumed
6 without prejudice to the state's right to raise the issue later
7 that this discovery is relevant. That the state will make a
8 production of relevant documents to us as soon as reasonably
9 practical recognizing that there, you know, there is no easy
10 way to do this and that the state has resource limitations.
11 That after that good faith production that we will be permitted
12 to depose Mr. Butt in his capacity as both commissioner and as
13 a 30(b)(6) witness on all of the topics that we have
14 designated. That the state and the counties will offer to us
15 proposed stipulations to limit the necessity to produce
16 documents that they consider to be particularly burdensome.
17 That we will meet and confer with respect to those
18 stipulations. That we will defer the depositions of the other
19 two deponents until such time as we've had an actual chance to
20 review the documents. It's certainly the defendants view that-
21 -

22 THE COURT: What about affidavits from them? Do you
23 want affidavits from them?

24 MR. MONTGOMERY: Well, we would certainly like to
25 see, we would like a representation as to what the state has

1 done. We do not find the assertion that they don't remember
2 any of the topics to be sufficient. We think that after we get
3 the documents if there's a particularly rich record that we're
4 entitled to try to refresh their recollections. But we are
5 agreed I think that we can defer until after we've seen the
6 documents and after the state has told us more about what we
7 can or cannot expect from those two witnesses.

8 We have agreed that--

9 THE COURT: Do you want the commissioner before you
10 get documents?

11 MR. MONTGOMERY: No.

12 THE COURT: No.

13 MR. MONTGOMERY: After.

14 THE COURT: After, okay.

15 MR. MONTGOMERY: We've agreed, you know, if it's
16 acceptable to Your Honor that the state and the counties will
17 file a report within 60 days with regard to their progress.
18 And though we didn't discuss this, we would request that the
19 Court set a further hearing at some point shortly after the
20 expiration of that 60-day period so that we're not unduly
21 delayed here. If we don't--

22 THE COURT: Do you want to pick a date now?

23 MR. MONTGOMERY: If we don't - we would, Your Honor.
24 And if we don't need it of course we're not going to come in
25 and burden Your Honor.

EXHIBIT D

Diane Dunstan - FW:Medicaid Pharmacy Article in Arkansas/discussion of lawsuit

Page 1 |

Item: #22

From: "Hanley, Ray" <Ray.Hanley@medicaid.state.ar.us>
To: "Partridge, Lee" <LPartridge@APHSA.ORG>, "Johnson, Kim" <KJohnson@aphsa.org>, "Smith, Vernon K." <vsmith@hlthmgt.com>, MASSACHUSETTS - Wendy Warring <Wendy.warring@state.ma.us>, ALABAMA - Michael Lewis <MLewis@medicaid.state.al.us>, ALASKA - Bob Labbe <Bob_labbe@health.state.ak.us>, ARIZONA - Phyllis Biedess <Pxbiedess@ahcccs.state.az.us>, CALIFORNIA - Gail Margolis <gmargoli@dhs.ca.gov>, COLORADO - Richard Allen <richard.allen@state.co.us>, CONNECTICUT - David Parella <david.parella@po.state.ct.us>, DELAWARE - Philip Soule <jHagler@state.de.us>, DISTRICT OF COLUMBIA - Herbert Weldon <Hweldon-doh@dcgov.org>, FLORIDA - Bob Sharpe <sharpeb@fdhc.state.fl.us>, GEORGIA - Mark Trail <Mtrail@dch.state.ga.us>, HAWAII -- Aileen Hiramatsu <Ahiramatsu@medicaid.dhs.state.hi.us>, IDAHO - Joe Brunson <BrunsonJ@idhw.state.id.us>, ILLINOIS - Jackie Garner <directordpa@mail.idpa.state.il.us>, INDIANA - Melanie Bella <Mbella@fssa.state.in.us>, IOWA - Cathy Anderson <canders@dhs.state.ia.us>, KANSAS - Robert Day <rmday@srskansas.org>, KENTUCKY - Ellen Heslen <Ellen.Heslen@mail.state.ky.us>, LOUISIANA - Ben Bearden <bbearden@dhh.state.la.us>, MAINE - Eugene Gessow <eugene.gessow@state.me.us>, MARYLAND - Debbie Chang <dchang@dhh.state.md.us>, WISCONSIN - Peggy Handrich <handrpl@dhs.state.wi.us>, MICHIGAN - Bob Smedes <smedesb@state.mi.us>, MINNESOTA - Mary Kennedy <mary.kennedy@state.mn.us>, "MISSISSIPPI - Mrs. Rica Lewis Payton" <exrcc@Medicaid.state.ms.us>, MISSOURI - Gregory Vadner <victornine@aol.com>, MONTANA - Margaret Bullock <Mbullock@state.mt.us>, NEBRASKA -- Robert Seiffert <bob.seiffert@hhss.state.ne.us>, NEVADA - Chuck Duarte <Pmanning@govmail.state.nv.us>, NEW HAMPSHIRE - Lee Bezanson <lbezanson@dhhs.state.nh.us>, NEW JERSEY -- Deborah Bradley <dcbradley@dhs.state.nj.us>, NEW MEXICO - Robert Maruca <Robert.Maruca@state.nm.us>, NEW YORK - Kathryn Kuhmerker <KLK03@HEALTH.STATE.NY.US>, NORTH CAROLINA -- Nina Yeager <nina.yeager@ncmail.net>, NORTH DAKOTA - David Zentner <sozend@state.nd.us>, OHIO - Barbara Edwards <Medicaid@odhs.state.oh.us>, "OKLAHOMA - Lynn V. Mitchell" <MitchellL@OHCA.state.ok.us>, OKLAHOMA - Mike Fogarty <Fogartym@ohca.state.ok.us>, OREGON - Lydia Lissman <Lydia.lissman@state.or.us>, PENNSYLVANIA - Peg Dierkers <PAMEDICAID@dpw.state.pa.us>, RHODE ISLAND - John Young <Jyoung@gw.dhs.state.ri.us>, SOUTH CAROLINA - Bill Prince <PrinceB@dhhs.state.sc.us>, SOUTH DAKOTA - Damian Prunty <Damian.Prunty@state.sd.us>, TENNESSEE - Mark Reynolds <mereynolds@mail.state.tn.us>, TEXAS - Linda Wertz <linda.wertz@hhsc.state.tx.us>, UTAH - Mike Deily <mdeily@doh.state.ut.us>, VERMONT - Paul Wallace-Brodeur <paulw@wpgate1.ahs.state.vt.us>, VIRGINIA -- Eric Bell <Bscott@dmas.state.va.us>, WASHINGTON - Jim Wilson <wilsojc@dshs.wa.gov>, WEST VIRGINIA -- Nancy Atkins <nancyatkins@wvdhhr.org>, "Johnson, Kim" <KJohnson@aphsa.org>, "Wiberg, Cody" <cody.c.wiberg@state.mn.us>, "Burch, Curtis" <Curtis.Burch@tdh.state.tx.us>, "Butt, Mark-Richard" <mrb01@health.state.ny.us>, "Duerr, Gary" <duerrg@idhw.state.id.us>, "Dunstan, Diane" <ddunstan@cms.hhs.gov>, "Parke, Duane" <hlhcf-1.dparke@state.ut.us>, "Reed, Larry" <LReed2@CMS.GOV>, "Reid, Bob" <reidr@odhs.state.oh.us>, "Shepherd, David" <dshepher@dmas.state.va.us>, "Wells, Jerry" <wellsj@fdhc.state.fl.us>
Date: Sat, Feb 9, 2002 9:58 AM
Subject: FW:Medicaid Pharmacy Article in Arkansas/discussion of lawsuit

We have obtained CMMS approval of a plan amendment to reduce pharmacy reimbursement effective March 1 to AWP minus 14%, generics (unless MACed) minus 25%, the fee stays at \$5.51. The changes are based on our Meyer & Stauffer survey. The attached newspaper article will surprise none of you that this action is not winning us awards of merit with the providers. We announced the change in late November as a part of a broader series of actions due to revenue shortfall, but would have made a change in pharmacy regardless. Strangely we got little protest and no counter proposal until after the feds approved the plan two weeks ago in part because of the distraction of our proposal to bid nursing home pharmacy to a single vendor (we got no bids, so moot point on that).

At the legislative hearing detailed in the article there was ready

acknowledgement that Medicaid is now the most profitable of all third party payers for pharmacy and no dispute that even after the change it will remain at least as profitable. The president of the Arkansas Pharmacist's Assoc. hit the issue even better than I could, from up scale college town 40 miles north of Little Rock, said 24% of his stores business is Medicaid---in response to a question from one of more supportive legislators the gentlemen acknowledged that yes, he accepts less than Medicaid payment levels from most of the other 76%---but that if he had to take same from Medicaid he would have to lay off an employee, and that one of his employees is his wife. I'm not unsympathetic, these are good people working hard to make a living in a market place that has changed markedly with managed care and PBM's---but I'm also challenged by law to live within the Medicaid allotted budget.

The threat is now there will be a lawsuit alleging that if we reduce payments access will be compromised(seeking to make a federal reg violation) when some stores in the depressed areas of the Mississippi close. What I expect to happen is they will find the most remote provider, bring him forward to say "yes, I will close if the new payment system is implemented". As near as we can tell case law doesn't support this point based only on predictions a store(s) would close---we think there is a case in Illinois that supports this. Truth is drug stores, and other businesses have been closing in the delta for years due to wholesale population shifts away from the area.

Any advice, case histories you might be familiar with would be much appreciated.

Ray

-----Original Message-----

From: Hanley, Ray

Sent: Friday, February 08, 2002 9:36 PM

To: Hanley, Ray

Subject:

Search Stories

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Contents

Pharmacists Oppose Medicaid Cuts By Elizabeth Caldwell Arkansas News Bureau LITTLE ROCK -- Pharmacies will close and Medicaid recipients will have difficulty getting prescription drugs under a plan designed to save the state money, lawmakers were told Thursday. Also, two state senators took Department of Human Services officials to task for cutting services to poor people to balance the state's budget. About 35 pharmacists attended a legislative Rules and Regulations Subcommittee on Thursday to protest reduced reimbursements for Medicaid prescriptions, set to take effect March 1. The reductions were announced in November to help offset a \$142 million budget shortfall, the largest in state history. David Smith of Conway, president of the Arkansas Pharmacists Association, told the subcommittee that pharmacies will layoff employees and some businesses will close or quit participating in Medicaid. "These people will not have access to care," Smith said. "You will see the ripple effect on the economy in these areas that are already economically depressed." He said one pharmacy has said it will lay off two employees and another will lose \$29,000, meaning another couple of layoffs. One Dermott pharmacy, that relies on Medicaid for half its business, will probably close; and another will lose

\$15,000 on brand name drugs. A Portland pharmacy likely could close and the next closest pharmacy is 20 miles away, Smith said. "We're talking about health care of our public. We cannot close our eyes to these people," Smith said. Ray Hanley, DHS' Medicaid director, said recent surveys show that the pharmacies will still be able to make a profit with the reduced reimbursement amounts. One reason for the high cost of the program is that physicians are prescribing high cost brand name drugs when generics would do. Hanley said the department has been working with physicians for three years to encourage them to change their prescription habits. Richard Beck, the association's executive vice president and chief executive officer, said Hanley hasn't done enough. He said DHS should require physicians to get prior approval to use many brand name drugs. He said the state could save \$2 million a year if it required physicians to switch to the generic for Prozac, a common antidepressant. Beck and Smith also said the state should raise the reimbursement on generic drugs as an incentive for physicians and pharmacists to switch from name brands. Sens. Terry Smith, D-Hot Springs, and Jodie Mahony, D-El Dorado, criticized Hanley for the way the department has responded to the budget shortfall. Smith asked Hanley if he had followed a 1997 directive from Gov. Mike Huckabee that requires state agencies to determine if a proposed policy change would affect families. Hanley said he had not, but said the cuts were "not inconsistent" with the Huckabee directive. "If we overspend and pay for things that are not medically necessary, that more than anything else, makes it harder to adhere to things like this and provide later services that are necessary," Hanley said. Mahony called DHS "totally irresponsible" for actions it has taken, or not taken, in dealing with the budget cuts. He said Hanley was "discouraging use of generic drugs" for not making it more difficult for physicians to prescribe brand names. Mahony also said DHS should have advocated for Huckabee to call a special legislative session to deal with the Medicaid cuts. Several legislators have said there are millions of dollars sitting in accounts that could be appropriated for Medicaid.

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EXHIBIT E



National Medicaid Pharmacy Administrators' Association

16th Annual Meeting

August 2 –4, 2002
San Francisco, CA

WAC+9% * AWP-10%
WAC+10% //
WAC+9% //
WAC+5% /
WAC+12% /



Welcome to the 16th Annual National Medicaid Pharmacy Administrators' Association Meeting

Welcome to San Francisco! Thank you for taking time from your busy schedules to attend the National Medicaid Pharmacy Administrators' Association Meeting. I hope you will find the meeting both fun and informative!

A special thanks to our friends in industry! The generous unrestricted educational grants received from the following companies provides Medicaid Pharmacy Administrators the opportunity to network with fellow professionals, explore new ideas, and make plans for the future:

Bristol-Myers Squibb

Fujisawa *Jim Turner*

Genentech - *Rene Black*

Pharmacia - *Jim McFadden*

TAP - *Jim Turner Knox*

The meeting agenda includes a Napa Valley tour on Saturday. If you have any free time during your stay in San Francisco, you may wish to visit Fisherman's Wharf, Pier 39, Ghirardelli Square, Chinatown, The Cannery, North Beach, The Golden Gate Bridge, or Alcatraz. The San Francisco Convention and Visitors Bureau has a Visitor Information Center, which is open 9 a.m. – 5 p.m. Monday – Friday, and 9 a.m. – 3 p.m. Saturday – Sunday. The telephone number for the Visitor Information Center is (415) 283-0177.

Have a wonderful time in San Francisco!

Sincerely,

Shannon Whalen

Shannon Whalen
2002 Chairman

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GENENTECH

PHARMACIA

TAP
PHARMACEUTICALS

AGENDA

NATIONAL MEDICAID PHARMACY ADMINISTRATORS' ASSOCIATION MEETING

AGENDA

Friday, August 2

1:00 p.m.

Business Meeting

2:30 p.m. – 2:45 p.m.

Break

2:45 p.m. – 5:00 p.m.

State Reports

5:30 p.m. – 7:00 p.m.

Reception

7:00 p.m.

Dinner

Saturday, August 3

7:30 a.m. – 8:30 a.m.

Breakfast

8:30 a.m. – 10:30 a.m.

**Kay Morgan
First Data Bank**

10:30 a.m. – 10:45 a.m.

Break

11:00 a.m.

**Depart for Lunch,
BioTechnology Tour,
Napa Valley Tour, and
offsite Dinner**

Sunday, August 4

7:30 a.m. – 8:30 a.m.

Breakfast

8:30 a.m. – 9:30 a.m.

Patsy McElroy, NCPDP

9:30 a.m. – 9:45 a.m.

Break

9:45 a.m. – 11:45 a.m.

**Donna Boswell
Legislative Update**

12:00 p.m.

Closing

STATES REPORTS

STATE REPORT: NMPAA 2002**STATE: ALABAMA****(For State Fiscal Year 2002—unless otherwise specified)**

1. Total Medicaid (MA) population: 2001—797,068 Total Medicaid Enrollees
 Fee for Service MA population: 2001—465,236 Total Pharm. Recipients
 Managed Care MA population: N/A
2. Annual spent on MA Drug Program: \$385,168,230
3. Total # Paid Pharmacy MA Claims: 9,719,394
4. Pricing Format (e.g. AWP-10%): WAC + 9.2%, AWP – 10%, DIR, SMAC, FUL
 Dispensing Fee(s): \$5.40

5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): _____

6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: N/A

7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: N/A

8. Status of Disease State Management Programs: Asthma Disease Management just beginning

9. Total Rebates Paid Since Inception of OBRA '90: \$371,047,502 – (10/93 – 9/01)
 Total Rebates Paid in 2001: \$ 76,713,500

10. Are Rebates Directed into State General Fund or Medicaid? Medicaid

11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE:ALASKA

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 93,219
Fee for Service MA population: 100%
Managed Care MA population: _____
2. Annual spent on MA Drug Program: \$69,186,228
3. Total # Paid Pharmacy MA Claims: _____
4. Pricing Format (e.g. AWP-10%): AWP – 5%
Dispensing Fee(s): _____

5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): N/A

6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: _____

7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: We began a Prior Authorization Program for Oxycontin, Oxycodone, Duragesic and Stadol NS.

8. Status of Disease State Management Programs: N/A

9. Total Rebates Paid Since Inception of OBRA '90: _____
Total Rebates Paid in 2001: \$12,240,395
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: ARIZONA (7/1/2001 –6/30/2002)
(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 787,573
Fee for Service MA population: 87,917
Managed Care MA population: 699,656
2. Annual spent on MA Drug Program: Data not available
3. Total # Paid Pharmacy MA Claims: Data not available
4. Pricing Format (e.g. AWP-10%): Managed care health plans: Formula based on
Dispensing Fee(s): discount from AWP plus dispensing fee.
Pricing is negotiated between individual pharmacy network and health plans or
their designated PBM.
FFS Members: AWP – 15% + \$2.00 dispensing fee
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Managed care health plans design
their own individual prescription drug and pharmacy benefit program to meet the needs
of their enrolled members. Health plans are all at full financial risk for providing
pharmacy benefits to their members.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Existing model has been in place since inception of
AHCCCS in 1982.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: The pharmacy benefit for both
managed care health plans and FFS incorporates a variety of management tools
including formularies, prior authorization, preferred drug lists, disease management
programs, etc. However, none are mandated by law or regulation.
8. Status of Disease State Management Programs: None are mandated by AHCCCS.
Most of the managed care health plans have incorporated some disease management
programs.
9. Total Rebates Paid Since Inception of OBRA '90: AHCCCS is waived from
participation in the Medicaid Drug Rebate program. Most of the managed care health
plans have some form of negotiated drug rebate either directly with pharmaceutical
manufacturers or through a PBM.
10. Are Rebates Directed into State General Fund or Medicaid? See #9
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: CONNECTICUT

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 333,000
Fee for Service MA population: 93,000
Managed Care MA population: 240,000
2. Annual spent on MA Drug Program: \$ 343 million
3. Total # Paid Pharmacy MA Claims: 5.6 million
4. Pricing Format (e.g. AWP-10%): AWP – 12%
Dispensing Fee(s): \$4.10

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5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Carved-in, no PCCM

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6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: ConPACE (CT's Rx program for the elderly/disabled) 1115 waiver submitted to CMS & in negotiations.

7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: Found out 2 DAYS AGO: state MAC (with supplemental rebates, P & T committee, preferred drug list), voluntary mail order, pharmaceutical purchasing initiative, cut dispensing fee.

8. Status of Disease State Management Programs: decided Diabetes would be the first last year, no other changes

9. Total Rebates Paid Since Inception of OBRA '90: \$ 373 million
Total Rebates Paid in 2001: \$ 78 million

10. Are Rebates Directed into State General Fund or Medicaid? Medicaid rebates returned to Medicaid; ConnPACE to General Fund.

11. Other issues SPECIFIC to State: dispensing fee decreases to \$3.85 on 9/1/02. ACS began Retro-DUR 4/1/02, Prior Auth contract with ACS pending.

STATE REPORT: NMPAA 2002

STATE: GEORGIA FY 2001

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 1,535,961 – eligibles
Fee for Service MA population: 415,640 – FFS eligibles
Managed Care MA population: 1,120,321 – GBHC eligibles
2. Annual spent on MA Drug Program: \$676,880,217
3. Total # Paid Pharmacy MA Claims: 16,125,897
4. Pricing Format (e.g. AWP-10%): AWP – 10%*
Dispensing Fee(s): \$4.63 for-profit pharmacies and \$4.33 for non-profit pharmacies* *Georgia has a most favored pricing law so pharmacies must pass along the lowest reimbursement they accept from any other payer to GA Medicaid.
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Georgia does not have a Medicaid HMO, but we do have a CHIP program – PCCM model and traditional FFS Medicaid.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: PBM contract
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: no state laws required to be passed for any initiatives implemented in FY01 for Medicaid.
8. Status of Disease State Management Programs: various disease management efforts under development or consideration
9. Total Rebates Paid Since Inception of OBRA '90: Data archived and not available by deadline. Total Rebates Paid in 2001: \$152,378,351.58
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: HAWAII

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 161,000
Fee for Service MA population: 36,000
Managed Care MA population: 125,000
2. Annual spent on MA Drug Program: \$ 72.8 million-Calendar Year 2001
3. Total # Paid Pharmacy MA Claims: 1,482,000-Calendar Year 2001
4. Pricing Format (e.g. AWP-10%): AWP – 10.5%, FUL, State Mac, usual & customary
Dispensing Fee(s): \$4.67
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Mainly carved-in. A few items are carved out: protease inhibitors, Synergis, Rebetrone, etc.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Dept. plans to apply for a 1115 waiver to include seniors who meet income criteria into Medicaid for drug cost assistance only.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: None
8. Status of Disease State Management Programs: Just starting
9. Total Rebates Paid Since Inception of OBRA '90: Not available
Total Rebates Paid in 2001: Not available
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid since 3Q 01
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: IDAHO

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 122,787 Average eligible per month SFY01
 Fee for Service MA population: 122,787 Average eligible per month SFY01
 Managed Care MA population: 0

2. Annual spent on MA Drug Program: \$99,326,161 SFY01

3. Total # Paid Pharmacy MA Claims: 1,984,977 SFY01

4. Pricing Format (e.g. AWP-10%): AWP - 12%
 Dispensing Fee(s): \$4.94

5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): All pharmacy benefits are fee-for-service. Idaho does use PCCM - Healthy Connections with approximately a 30% enrollment.

6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: No

7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: Early refill (75% -2/02), PA of COX II, PPI, non sedating antihistamines (5/02), tightening of quantity limits—requiring PA to override (rule being written).

8. Status of Disease State Management Programs: Asthma and Diabetes Disease Management programs in in development. Projected implementation date is 4th Quarter of 2002.

9. Total Rebates Paid Since Inception of OBRA '90: \$68,281,101 through SFY 01
 Total Rebates Paid in 2001: \$17,269,205 SFY 01

10. Are Rebates Directed into State General Fund or Medicaid? Medicaid

11. Other issues SPECIFIC to State: (1) 2002 Legislative direction to PA all Rx's/client >4/month beginning 4/01. Program placed on hold 4/5/01. (2) Began PA on Cox II inhibitors, PPI, and non sedating antihistamines 5/02. (3) Allocation of cyberperformance data mining technology from Heritage to support DUR program and lock-in program, as well as other new initiatives.

STATE REPORT: NMPAA 2002

STATE: ILLINOIS

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 1,927,595
Fee for Service MA population: 1,459,459
Managed Care MA population: 468,136
2. Annual spent on MA Drug Program: \$967,151,575.00
3. Total # Paid Pharmacy MA Claims: 22,528,018
4. Pricing Format (e.g. AWP-10%): FY02= Brand: AWP – 11% and Generic: AWP – 20%. FY03=Brand: AWP – 12% and Generic: AWP – 25%
Dispensing Fee(s): FY02=Brand: \$4.00 and Generic: \$5.10.
FY03=Brand: \$3.40 and Generic: \$4.60
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Pharmacy is NOT carved out of managed care. Managed care entities must operate a formulary that is no more restrictive than the Department's benefit. This includes a requirement that they may only put prior authorization on drugs our regular program has on prior authorization.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Have an operating 1115 B Waiver making our Senior's Program Title XIX matchable. Have begun including the net cost of drugs as a larger component of the decision making process for which drugs require prior authorization. Net cost is measured after considering any supplemental rebates offered by each manufacturer.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: None
8. Status of Disease State Management Programs: Couple of pilots going. No results to report.
9. Total Rebates Paid Since Inception of OBRA '90: \$1,084,816,985.07
Total Rebates Paid in 2001: \$ 159,937,834.00 (FY02)
10. Are Rebates Directed into State General Fund or Medicaid? Special Medicaid fund which can only be spent to reimburse pharmacies.
11. Other issues SPECIFIC to State: Increasing federal FFP match rate.

STATE REPORT: NMPAA 2002**STATE: IOWA****(For State Fiscal Year 2002—unless otherwise specified)**

1. Total Medicaid (MA) population: 220,116* (*monthly ave. of people eligible)
 Fee for Service MA population: 102,188
 Managed Care MA population: 117,928
2. Annual spent on MA Drug Program: \$225,322,393
3. Total # Paid Pharmacy MA Claims: 5,037,219
4. Pricing Format (e.g. AWP-10%): AWP – 10%
 Dispensing Fee(s): \$5.17
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Pharmacy benefits are carved-out.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: State MAC
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: N/A
8. Status of Disease State Management Programs: N/A
9. Total Rebates Paid Since Inception of OBRA '90: \$ 238.5 million
 Total Rebates Paid in 2001: \$ 45,341,315
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: KANSAS

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 183,788
Fee for Service MA population: 44,194
Managed Care MA population: 11,981
2. Annual spent on MA Drug Program: \$188,582,079
3. Total # Paid Pharmacy MA Claims: 3 to 4 million per year
4. Pricing Format (e.g. AWP-10%): AWP – 10%, AWP – 30% blood fraction products, and AWP – 50% large volume parenterals. Also MAC pricing
Dispensing Fee(s): \$4.50
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): PCCM fee for service and benefit carved-in for managed care
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: No
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs No
8. Status of Disease State Management Programs: None
9. Total Rebates Paid Since Inception of OBRA '90: Unavailable
Total Rebates Paid in 2001: FY 2001: \$35,280,317 FY 2001: \$42,467,334
10. Are Rebates Directed into State General Fund or Medicaid? State General Funds
11. Other issues SPECIFIC to State: No

STATE REPORT: NMPAA 2002

STATE: MARYLAND FY 2001

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 581,000
Fee for Service MA population: 137,000
Managed Care MA population: 444,000
2. Annual spent on MA Drug Program: \$ 270 million
3. Total # Paid Pharmacy MA Claims: 4.5 million
4. Pricing Format (e.g. AWP-10%): WAC + 10
Dispensing Fee(s): \$4.21 retail & \$5.25 NH
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Carved-in except Mental Health
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Expand Senior Program
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: 10 prescription limit per month
8. Status of Disease State Management Programs: No Program
9. Total Rebates Paid Since Inception of OBRA '90: \$ 363 million
Total Rebates Paid in 2001: \$ 50 million
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: MASSACHUSETTS

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 947,948 (Ave. number of members enrolled)
Fee for Service MA population: 784,755 (Ave. number of members enrolled)
Managed Care MA population: 163,193 (Ave. number of members enrolled)
2. Annual spent on MA Drug Program: Approximately \$769 million
3. Total # Paid Pharmacy MA Claims: Approximately 14.9 million
4. Pricing Format (e.g. AWP-10%): WAC + 10%
Dispensing Fee(s): \$3.00
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Pharmacy is carved-in to MCO benefit. State uses a PCC (primary care physician) program that, unlike the MCO's, is fee for service.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: 1115 Waiver Expansion to include HIV infected individuals how are <200% FPL.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: New Oct. '01 pharmacy regulations that expand access to certain pharmaceuticals; OTC's, Topical Acne Preparations, ADHD drugs, while tightening restrictions on other products, such as: Erectile Dysfunction, Obesity, Multi-Source Brand Drugs. In addition, prescriptions will now be valid for 1-year or 11 refills when applicable. Quantity limits are 30 - 90 days where appropriate.
8. Status of Disease State Management Programs: State does not engage in DSM. The State does employ Treatment Guidelines.
9. Total Rebates Paid Since Inception of OBRA '90: \$914,457,082
Total Rebates Paid in 2001: \$161,958,511
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: MISSOURI

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 818,109
Fee for Service MA population: 472,238
Managed Care MA population: 345,871
2. Annual spent on MA Drug Program: \$708,180,772
3. Total # Paid Pharmacy MA Claims: 14,008,569
4. Pricing Format (e.g. AWP-10%): Federal Upper Limit
Dispensing Fee(s): \$8.04 Dispensing Fee: \$8.19 Nursing home
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Protease inhibitors are carved out. All other Pharmacy benefits are the responsibility of the MC+ Health Plans.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Pharmacy Provider Tax and Enhanced Dispensing Fee; Prior Authorization of New Drugs; Disease Management Program.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: Prior Authorization of New Drugs; Elimination of over-the-counter coverage (except insulin); Dose Optimization; Early Refill Edits; 31 Day Maximum Supply.
8. Status of Disease State Management Programs: We are currently in the final stages of awarding a contract.
9. Total Rebates Paid Since Inception of OBRA '90: \$764,825,819.31
Total Rebates Paid in 2001: \$105,871,972.93
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: Pharmacy Provider Tax and Enhanced Dispensing Fee; Prior Authorization of New Drugs; Disease Management Programs; Elimination of over-the-counter Coverage (except Insulin); Dose Optimization; Early Refill Edits; 31 day Maximum Supply.

STATE REPORT: NMPAA 2002

STATE: MONTANA

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 162,136
Fee for Service MA population: N/A
Managed Care MA population: N/A
2. Annual spent on MA Drug Program: \$69,503,391.04 (through May 2002)
3. Total # Paid Pharmacy MA Claims: 902,473
4. Pricing Format (e.g. AWP-10%): Lesser of : 1) Estimated Acquisition Cost (EAC) plus dispensing fee. 2) Federal upper limit (FUL)/maximum allowable cost (MAC) of the drug plus dispensing fee; or 3) Provider's usual and customary charge. *EAC is currently AWP less 15% (effective July 1, 2002)
Dispensing Fee(s): Dispensing fee is maximum \$4.70 for in-state pharmacies and maximum \$3.50 for out-of-state pharmacies
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): The pharmacy benefit within managed care is carved out.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Initiatives include changes to reimbursement (effective July 1); changes to cost sharing (effective April 1, 2002); pursuit of waivers; pharmacy case management model.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: N/A
8. Status of Disease State Management Programs: We are not currently pursuing any disease state management programs.
9. Total Rebates Paid Since Inception of OBRA '90: \$83,573,602
Total Rebates Paid in 2001: \$12,750,802
10. Are Rebates Directed into State General Fund or Medicaid? Rebates collected are directed into the state general fund.
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: NEVADA

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 141,000
Fee for Service MA population: 93,000
Managed Care MA population: 48,000
2. Annual spent on MA Drug Program: \$ 60 million
3. Total # Paid Pharmacy MA Claims: 1,417,414
4. Pricing Format (e.g. AWP-10%): AWP – 10.% + dispensing fee (may change)
Dispensing Fee(s): \$4.76
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Anti-retrovirals are carved-out of managed care, revert to FFS. State is in the process of submitting and RFP for PCCM
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Implementation of POS early 2003
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: PA is not a state regulation, however implemented PA on PPI, COX2, and viagra effective 7/1/02 and no grandfathering.
8. Status of Disease State Management Programs: Working on provider & recipient outreach programs.
9. Total Rebates Paid Since Inception of OBRA '90: \$56,315,380
Total Rebates Paid in 2001: \$ 18,416,742
10. Are Rebates Directed into State General Fund or Medicaid? State General Fund
11. Other issues SPECIFIC to State: Had a public hearing on 7/8/02 to increase to AWP – 15% + \$4.76

STATE REPORT: NMPAA 2002

STATE: NEW HAMPSHIRE

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 110,232
Fee for Service MA population: N/A
Managed Care MA population: 8,797
2. Annual spent on MA Drug Program: \$ 87,999,033.70
3. Total # Paid Pharmacy MA Claims: 1,919,114
4. Pricing Format (e.g. AWP-10%): Lesser of AWP – 12%, FUL, or State MAC
Dispensing Fee(s): \$2.50
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Pharmacy Benefit is carved-out of managed care.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: NH implemented a PBM contract with First Health on November 3, 2001.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: New Administrative Rules. New 570 to allow Prior Authorization and Lock in.
8. Status of Disease State Management Programs: In the process of developing a DSM program with First Health.
9. Total Rebates Paid Since Inception of OBRA '90: \$77,511,415.27
Total Rebates Paid in 2001: \$10,863,978.66
10. Are Rebates Directed into State General Fund or Medicaid? General Fund.
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: NORTH DAKOTA

Data from current biennium (through June 30 – SFY 2002

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 47,788
Fee for Service MA population: 47,788
Managed Care MA population: N/A
2. Annual spent on MA Drug Program: \$37,237,493
3. Total # Paid Pharmacy MA Claims: 1,071,983
4. Pricing Format (e.g. AWP-10%): AWP – 12%
Dispensing Fee(s): \$4.60
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): N/A

6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: None
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: None
8. Status of Disease State Management Programs: Identifying patients with asthma and diabetes to be managed by 6 pharmacists in the state.
9. Total Rebates Paid Since Inception of OBRA '90: \$54,776,363.15
Total Rebates Paid in 2001: \$ 9,951,023.00
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: Current budget shortfall for Medicaid is \$18 million.

STATE REPORT: NMPAA 2002

STATE: OHIO SFY 2001

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 1.4 million
Fee for Service MA population: 1.1 million
Managed Care MA population: 0.3 million
2. Annual spent on MA Drug Program: \$ 1,112,356
3. Total # Paid Pharmacy MA Claims: 25,170,558
4. Pricing Format (e.g. AWP-10%): WAC + 9%
Dispensing Fee(s): \$3.70
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Carved-in. State uses First Health for POS and PA.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: In process: A state plan amendment to allow for a preferred drug list and supplemental rebates.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: In process, see #6.
8. Status of Disease State Management Programs: None.
9. Total Rebates Paid Since Inception of OBRA '90: Not readily available
Total Rebates Paid in 2001: \$245,436,770 SFY 2001
10. Are Rebates Directed into State General Fund or Medicaid? General Fund
11. Other issues SPECIFIC to State: We've always had a large PA program. Approximately 26,000 claims/year via PA.

STATE REPORT: NMPAA 2002

STATE: OKLAHOMA

(For State Fiscal Year 2001 – July 1, 2000 to June 30, 2001)

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: Average monthly enrollment of 432,922
Fee for Service MA population: Average monthly enrollment 141,650
Managed Care MA population:
Capitated HMO: Average monthly enrollment 163,103
PCP/CM (FFS RX): Average monthly enrollment 128,169
2. Annual spent on MA Drug Program: \$ 202,094,418.00
3. Total # Paid Pharmacy MA Claims: 4,383,471
4. Pricing Format (e.g. AWP-10%): AWP – 10.5% (currently AWP – 12%)
Dispensing Fee(s):
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Oklahoma has two managed care options. SoonerCare Plus is a capitated HMO system that includes pharmacy benefits provided by the HMO. SoonerCare Choice is a PCP/CM system with pharmacy benefits provided by and equal to the Fee for Service pharmacy benefit.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: N/A
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: Oklahoma continues to expand the Product Based Prior Authorization program. This program is much like a preferred drug list but is confined to therapeutic categories that the DUR Board approves based on clinical and economic analysis. In January 2000, the program started with the Anti-Ulcer and NSAID categories. In the Fall of 2001, the DUR Board approved the addition of ACE Inhibitors, Calcium Channel Blockers and their combination products to the PBPA Program. These changes were made in April 2002. During the 2002 Legislative Session, a bill was passed that requires the state Medicaid agency to study the feasibility of disease management in the Medicaid population.
8. Status of Disease State Management Programs: Disease Management is not coordinated through the pharmacy department. One program for pediatric asthmatics was conducted during FY 01-02 and an asthma collaboration with the Indian Health Service clinics has just begun in Spring of 2002.
9. Total Rebates Paid Since Inception of OBRA '90: \$231,721,956.00
Total Rebates Paid in 2001: \$ 40,032,307.00
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. N/A

STATE REPORT: NMPAA 2002**STATE: OREGON****(For State Fiscal Year 2002—unless otherwise specified)**

1. Total Medicaid (MA) population: 356,002
 Fee for Service MA population: 152,728
 Managed Care MA population: 203,274
2. Annual spent on MA Drug Program: \$ 225,489,467
3. Total # Paid Pharmacy MA Claims: 4,340,264
4. Pricing Format (e.g. AWP-10%): AWP – 13%
 Dispensing Fee(s): \$3.50, \$3.80 NF
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): MCO's capitation includes the pharmacy benefit except for Standard therapeutic class 7 & 11 which are paid for FFS. Oregon also utilizes a PCCM program and the pharmacy benefit is also paid FFS.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: New expansion proposal recently submitted to CMS under an 1115 and HIFA waiver. A new reduced "commercial type" benefit package is proposed for the new eligibles. As for the mandatory Medicaid eligible populations, Oregon is implementing a \$2 generic, \$3 Brand drug copay effective 8/1/02. Effective 3/1/02 implemented a State MAC which has saved the state approx \$1 million per month on our drug expenditures. Also implementing a "preferred drug list" type of formulary effective 8/1/02, restricting clients to a single pharmacy, limits the initial dispensing of maintenanced med's to 15 days supply.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: SB 819 which allows the agency to develop a preferred drug list.
8. Status of Disease State Management Programs: Oregon is currently in the process of designing a program case management of asthmas, diabetes, CHF and high utilizers
9. Total Rebates Paid Since Inception of OBRA '90: \$179,399,117.01
 Total Rebates Paid in 2001: 50,419,520.20
10. Are Rebates Directed into State General Fund or Medicaid? General Fund
11. Other issues SPECIFIC to State: N/A.

STATE REPORT: NMPAA 2002

STATE: RHODE ISLAND

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 172,190 (figures are for 6-02)
Fee for Service MA population: 48,192
Managed Care MA population: 130,199
2. Annual spent on MA Drug Program: SFY 2001 \$101,041,334
SFY 2002 \$120,952,122
3. Total # Paid Pharmacy MA Claims: 2.5 million
4. Pricing Format (e.g. AWP-10%): WAC + 5%
Dispensing Fee(s): \$3.40 ambulatory, \$2.85 Nursing Facility
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): carved-in
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: 1115 Pharmacy Waiver in development
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid; Including Prior Authorization or Use of PBMs: Expansion of PA Program through on-line system 11-02. Adding PPIs and COX IIs
8. Status of Disease State Management Programs: Connect CARRE presently enrolled 40 recipients. 35 recipients in review process. Developing program for CHF.
9. Total Rebates Paid Since Inception of OBRA '90: since SFY 1995, \$115 million
Total Rebates Paid in 2001: SFY 2001, \$22.6 million
10. Are Rebates Directed into State General Fund or Medicaid? General Fund
11. Other issues SPECIFIC to State: Pro DUR Alerts now deny. Pharmacist intervention required for override. Switching to NCDPDP 5.1 processing 11/02.

STATE REPORT: NMPAA 2002

STATE: SOUTH CAROLINA

(For State Fiscal Year July 2001 – June 2002)

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 689,153
Fee for Service MA population: 653,068
Managed Care MA population: 36,085
2. Annual spent on MA Drug Program: \$ 427,707,138 (before rebates deducted)
3. Total # Paid Pharmacy MA Claims: 8,195,237
4. Pricing Format (e.g. AWP-10%): AWP less 10%
Dispensing Fee(s): \$4.05
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): For Medicaid Managed Care the Pharmacy Benefit is Carved-in. South Carolina uses a PBM to adjudicate pharmacy claims, administer our Prior Approval (PA) process and to develop and maintain our SC MAC list.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: A 1115 waiver is pending to convert and expand our current state only prescriptions program for seniors to a Medicaid matched program rebates.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: 34-day maximum supply per Rx; PA of PPIs and COX 2s; expanded SC MAC List.
8. Status of Disease State Management Programs: Limited, but looking to expand.
9. Total Rebates Paid Since Inception of OBRA '90: \$449,768,481 approximately
Total Rebates Paid in 2001: \$102,196,236
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid Pharmacy Program.
11. Other issues SPECIFIC to State: N/A.

STATE REPORT: NMPAA 2002

STATE: SOUTH DAKOTA

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 87,000
Fee for Service MA population: 87,000
Managed Care MA population:
2. Annual spent on MA Drug Program: \$ 58,290,728
3. Total # Paid Pharmacy MA Claims: 1,200,000
4. Pricing Format (e.g. AWP-10%): AWP – 10.5%
Dispensing Fee(s): \$4.75 + 0.80 for unit dose
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): No Managed Care.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: In process: Nothing for sure at this time.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: None.
8. Status of Disease State Management Programs: None.
9. Total Rebates Paid Since Inception of OBRA '90: \$41,000,000
Total Rebates Paid in 2001: \$ 12,753,091
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: TEXAS

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 2 million +
Fee for Service MA population: 66.65%
Managed Care MA population: 33.35%
2. Annual spent on MA Drug Program: \$ 1,331,661,273
3. Total # Paid Pharmacy MA Claims: 27,904,381
4. Pricing Format (e.g. AWP-10%): EAC=AWP – 15% or WAC + 12%
Dispensing Fee(s): (EAC+ \$5.27 divided by 0.980= amount paid +
0.15 delivery service.
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Pharmacy Benefit Carved-out
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: None.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: None.
8. Status of Disease State Management Programs: Physician based diabetes pilot program in Bexar.
9. Total Rebates Paid Since Inception of OBRA '90: \$1,631,268,847.73 (+89 pre OBRA from Syntex)
Total Rebates Paid in 2001: \$ 268,269,745.51
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: UTAH

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 275,000 eligible – 190,000 recipients
Fee for Service MA population: 169,000
Managed Care MA population: having managed care by 2003
2. Annual spent on MA Drug Program: \$ 135 million in FY 2002 just over
3. Total # Paid Pharmacy MA Claims: N/A
4. Pricing Format (e.g. AWP-10%): AWP – 12%
Dispensing Fee(s): \$3.90 urban \$4.40 rural
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): carved-out.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Two new Medicaid programs, non traditional and Primary Care with different benefits.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: Nursing home return goods law.
8. Status of Disease State Management Programs: None with Medicaid.
9. Total Rebates Paid Since Inception of OBRA '90: \$N/A
Total Rebates Paid in 2001: \$125 million program, \$29 million rebate(2001 Calendar Year.
10. Are Rebates Directed into State General Fund or Medicaid? General Fund.
11. Other issues SPECIFIC to State: 7 Rx limit, PCN program with 4 Rx limit

STATE REPORT: NMPAA 2002

STATE: WEST VIRGINIA

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 259,009
Fee for Service MA population: 127,778
Managed Care MA population: 131,231
2. Annual spent on MA Drug Program: \$ 241,058,041
3. Total # Paid Pharmacy MA Claims: 6,128,570
4. Pricing Format (e.g. AWP-10%): AWP – 12%
Dispensing Fee(s): \$3.90 (4.90 compounds)
(\$5.19-\$41.03 for home infusion compounding)
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Carved-Out; Yes for PCCM
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: RFP ready for release for fiscal agent; RFP will soon be released for Retro-DUR; State pland amendment sent for PDL.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: House Bill 4666 passed into law to authorize a preferred drug list with supplemental rebates.
8. Status of Disease State Management Programs: Diabetes program implemented 10/01.
9. Total Rebates Paid Since Inception of OBRA '90: \$256,173,735
Total Rebates Paid in 2001: \$ 44,602,150
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: Cost containment initiatives – reduction of pharmacy reimbursement, development of state MAC program.

STATE REPORT: NMPAA 2002

STATE: WISCONSIN
(July 1, 2001 – June 30, 2002)

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 584,388 to May 31, 2002
Fee for Service MA population: 269,433
Managed Care MA population: 314,955 (AFDC/Related SCHIP (XXI),
SSI/Related.
2. Annual spent on MA Drug Program: \$ 390,119,126 to May 31, 2002
3. Total # Paid Pharmacy MA Claims: 7,778,848 to May 31, 2002
4. Pricing Format (e.g. AWP-10%): AWP – 10% to 6/30/2001; AWP – 11.2% from
7/01/2002.
Dispensing Fee(s): \$4.88 to \$40.01
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Carved-in. No PCCM.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Senior Care (65 or older)
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: None.
8. Status of Disease State Management Programs: Targeted interventions done internally.
9. Total Rebates Paid Since Inception of OBRA '90: \$490,437,037 (Records available from 1192 to May 31, 2002)
Total Rebates Paid in 2001: \$ 89,590,400
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: WYOMING

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 51,949 (15,750 pharmacy recipients)
Fee for Service MA population: 51,949
Managed Care MA population: N/A
2. Annual spent on MA Drug Program: \$ 35,003,033
3. Total # Paid Pharmacy MA Claims: 667,556
4. Pricing Format (e.g. AWP-10%): AWP – 11%
Dispensing Fee(s): \$5.00
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): No Managed Care.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: PA program, implementation date September 1, 2002.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: None.
8. Status of Disease State Management Programs: Considering implementation of Disease Management Program, no formal program at this time.
9. Total Rebates Paid Since Inception of OBRA '90: \$34,222,636 (documented since 1992.
Total Rebates Paid in 2001: \$ 5,761,286 (first 3 Qtrs.)
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: DELAWARE

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 119,188
Fee for Service MA population: 27,808
Managed Care MA population: 91,380
2. Annual spent on MA Drug Program: \$ 93,743,272
3. Total # Paid Pharmacy MA Claims: 1,683,215
4. Pricing Format (e.g. AWP-10%): AWP – 12.9%
Dispensing Fee(s): \$3.65
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Carved-out.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: Breast and Cervical Cancer Expansion.
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: All Brand product require PA if a generic is available. Delaware has significantly expanded other drugs that require authorization.
8. Status of Disease State Management Programs: Several initiatives are in various stages of development.
9. Total Rebates Paid Since Inception of OBRA '90: \$ 84 million
Total Rebates Paid in 2001: \$18,252,000
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: Implement NCPDP 5.1 including compound prescriptions.

STATE REPORT: NMPAA 2002

STATE: MISSISSIPPI

(For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 600,000
Fee for Service MA population: 600,000
Managed Care MA population: 0
2. Annual spent on MA Drug Program: \$ 465 million
3. Total # Paid Pharmacy MA Claims: 9 million
4. Pricing Format (e.g. AWP-10%): AWP – 10.%
Dispensing Fee(s): \$4.91
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): N/A
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: PBM contract services
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: House Bill 1200, Senate Bill 2189.
8. Status of Disease State Management Programs: RFP issued.
9. Total Rebates Paid Since Inception of OBRA '90: DKA
Total Rebates Paid in 2001: DKA
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002**STATE: NEW YORK****(For State Fiscal Year 2002—unless otherwise specified)**

1. Total Medicaid (MA) population: 2,892,000
 Fee for Service MA population: 2,162,000
 Managed Care MA population: 730,000
2. Annual spent on MA Drug Program: \$ 2,971,000,000
3. Total # Paid Pharmacy MA Claims: 54,678,000
4. Pricing Format (e.g. AWP-10%): AWP - 10%
 Dispensing Fee(s): \$4.50 Brand, \$5.50 generic
 \$ 3.50 4.50
5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Pharmacy services are currently carved-out of managed care.
6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: (1) Mandatory generic program, (2) Voice interactive telephone prior authorization, (3) Expansion of EPIC (senior drug program), (4) NewFamily Health Plus (federal waiver).
7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: As of 10/1/02: No "A" rated brands dispensed unless (1) specifically exempted or (2) prescribers obtain prior authorization number.
8. Status of Disease State Management Programs: Active disease management plans for asthma, diabetes and smoking cessation.
9. Total Rebates Paid Since Inception of OBRA '90: \$2,397,000,000
 Total Rebates Paid in 2001: \$ 500,000,000
10. Are Rebates Directed into State General Fund or Medicaid? Medicaid
11. Other issues SPECIFIC to State: N/A

STATE REPORT: NMPAA 2002

STATE: NORTH CAROLINA—SFY 2001 (For State Fiscal Year 2002—unless otherwise specified)

1. Total Medicaid (MA) population: 1,354,593
 Fee for Service MA population: 684,593
 Managed Care MA population: 670,000

2. Annual spent on MA Drug Program: \$931,725,857

3. Total # Paid Pharmacy MA Claims: 17,428,527

4. Pricing Format (e.g. AWP-10%): AWP – 10%
 Dispensing Fee(s): \$5.60 generics, \$4.00 Brand (changed SFY 02)

5. Parameters of Pharmacy Benefit Within Medicaid Managed Care (e.g.: Is Pharmacy Benefit Carved-in or Out; does State use PCCM?): Carved-out in Access (PCCM) and MC contracts.

6. New Medicaid Initiatives by State Including Sect. 1115 Waiver, Waiver Expansion, Pilot Program, or PBM Contract: No new initiatives. Currently PBM for PA. Anticipate PDL development.

7. New State Laws or Regulations Impacting Access to Pharmaceuticals Within Medicaid, Including Prior Authorization or Use of PBMs: PBM – help desk for PA.

8. Status of Disease State Management Programs: Asthma, Diabetes.

9. Total Rebates Paid Since Inception of OBRA '90: \$756,126,118
 Total Rebates Paid in 2001: \$170,299,323

10. Are Rebates Directed into State General Fund or Medicaid? Medicaid

11. Other issues SPECIFIC to State: N/A

SPEAKERS

KAY MORGAN

Manager, Product Knowledge Base Services First DataBank

Kay Morgan joined First DataBank as the Manager of Product Knowledge Base Services in April of 1999. In her present position, Kay is responsible for the acquisition and maintenance of product and pricing information for the NDDF, MDDDB, and PIF databases. She is also responsible for the databases editorial policies for defining package size, billing unit, generic status and many other fields of interest to the NCPDP membership.

Prior to joining First DataBank, Kay was employed by Abbott Laboratories for more than 20 years in various positions. These included Research & Development, Product Information, Third Party Reimbursement, Marketing, Trade Relations, Managed Care, and Customer Service Operations. Kay was instrumental in increasing Abbott support for NCPDP and manufacturer awareness of the standards set by NCPDP.

Kay has a B.S. in Pharmacy from the University of Missouri in Kansas City and serves on the Dean's Advisory Panel. She has also been named one of the Outstanding Women in Pharmacy.

Pricing Methodologies: Sources and Definition

Objectives

- NCPDP Standard for Formatting NDCs
- NCPDP Billing Units and Exceptions
- NDDF Pricing Data Elements
- NDDF Generic Indicators

National Drug Code (NDC)

- Title XIX –Required Tracking System for Drugs
- NDC Consists of 10 Digits
 - 4-4-2
 - 5-3-2
 - 5-4-1
- 1st - 4 or 5 is Labeler Code – FDA Assigned
- 2nd -3 or 4 is Product Identifier
- 3rd - 1 or 2 is Package Size

NDC Continued

- NCPDP Set NDC # at 11 Digits
- Add 0 to 10 for Standardization
- Set Methodology for Adding 0

NDC Continued

- 4-4-2 0 is in First Position 04-4-2
- 5-3-2 0 is in the Sixth Position 5-03-2
- 5-4-1 0 is in the Tenth Position 5-4-01
- Applies to NDC's ONLY

Non- NDCs

- UPC – Universal Code Council
 - 5-5 Format
 - 0 in 6th Position: 5-05
- HRI – FDA Assigned Labeler Code
 - 4-6 Format
 - 0 in 1st Position: 04-4-2
- PIN Number – Supplier Created
 - 0 May Not Exist

File Has All NDCs?

- Field Name is "NDC"
- NDC Format Indicator (NDCF1)
 - Indicates Format for Number in NDC Field
 - 7 Values

There is an Indicator on the file
to show if UPC, NDC

Format Indicator - 4, 5, 6 = UPC

1, 2, 3 = NDC

OTCs may have UPC - PDA does not
require they have NDCs

Billing Units

- NCPDP Standard Requires:
 - Each
 - Milliliter (mL)
 - Gram (Gm)
- NCPDP Rounding:
 - Ounces
 - 1 ounce = 30 mL or 30 gm unless stated on label

What Is a 1?

- 1 Tablet or 1 Bottle of 100 Tablet
 - NCPDP - 1 Tablet
 - CMS - Either 1 Tablet or 1 Bottle
- RESULT - 100 Fold Difference In Rebate Claim

What Is an ML?

- Majority of Liquids Labeled in Ounces
 - Determine mL by multiplying by 30 unless on specific mL on label
 - Manufacturer reports exact conversion (29.57)
- RESULT – 0.5 mL discrepancy for each ounce

Powders For Reconstitution

- Injectable
 - 1 each - not number of mLs after reconstitution
- Oral
 - Number of mLs after reconstitution
 - Further Dilution with another diluent irrelevant

Issues With Package Size

- Some have reported bottle size
 - 100 mL bottle - after reconstitution 75 mL
 - 3 mL bottle - contained 2.5 mL
 - Result
 - Under payment to pharmacy
 - Discrepancies in rebate claims
- Patches
 - 1 patch not 1 box

Issues With Package Size

- Birth Control Pills
 - # of Tablets not 1 package
 - Result is 21 or 28 fold discrepancy
- Ointments
 - # of grams not one tube
- Never in terms of Dose

Antihemophilic - variable potency
- billing per unit

* Prolaslin - mcg

* Novoswen - mcg

Determining Package Size

- Think in terms of Dispensable Units
- Not Saleable Units
 - 10 bottles is not an NCPDP Billing Unit
- Use of NCPDP Billing Unit Standard for Package Sizes Minimizes:
 - Under/Overpayment on claims
 - Rebate Discrepancies

NDDF™ Pricing Information

- Average Wholesale Price (AWP)
- BaseLine Price (BLP)
- Customized Pricing
- Direct Price
- HCFA Federal Upper Limits Price
- Historical Pricing
- Medicaid Billing Data



GCN/GCNSEQNO

- Groups Products by
 - Active Ingredient
 - Dosage Form
 - Route of Administration
 - Strength
- Candidates for Substitution

It's Not the Money

- Most Dynamic Fields on Data On Databases
- Most Excitement as it Affects Payment
 - Patient
 - Pharmacist
 - Physician
 - Payer

Pricing Information Sources

- WHN (WAC) - Manufacturer/Supplier - *from manufacturer*
- Direct - Manufacturer/Supplier
- AWP - Wholesaler Survey
- SWP - Manufacturer/Supplier - *suggested wholesale price - from manufacturer*
- Medicaid AWP - DoJ
- HCFA Upper Limit - CMS
- Baseline Price - FDB Formula

*Direct ≠ WAC
Abbott
only mchft*

no wholesalers are responding

Price Update Frequency

- Daily for Master File
- Customers Chose
 - Daily
 - Weekly
 - Monthly
 - Semi-Monthly
 - Bi-Monthly
 - Quarterly

AWP

- Average Wholesale Price
- Published Price from Wholesaler to Retail
- Ain't What's Paid
- Benchmark for Reimbursement
- National/Standard AWP Does Not Exist

BBAWP/AWP

- AWP Unit
 - Survey Wholesalers for Mark-up
 - Confirm Mark-ups Periodically
 - Update When notified by Labeler
 - Most Commonly Used

across product line -
labeler code



only national wholesalers

*Forward buying - wholesaler buy up before price ↑
Markup applied to WAC/WHN Price
Mck, Bogen, Cardinal*

20% Markup

25% Markup

Suggested WP

80% of the WACS populated on whole database

multi source

*AWP - %
or
WAC + % } whichever is lower*

WHN/WAC Price

- Wholesale Acquisition Cost
- Provided by Manufacturer
- Published Price from Manufacturer to Wholesaler
- Used by Some Payers
- > 80% Populated on Commercially Available Drugs

Brand. S. Source products -

pretty close

Generics - vary

Volume buying discounts

legitimate

** WAC pricing for multisource -*

Major

HCFA FUL Price

- HCFA (Health Care Financing Administration) FFP (Federal Financial Participation)
- FUL (Federal Upper Limit) AKA MAC
- Updated When Notified By CMS (HCFA)

3 suppliers - use lowest WAC

X / 50%

Medicaid AWP

- New Data Element
- Can Be Used by Medicaid for Reimbursing on Select Products
- Prices Given to FDB by DoJ
- FDB Surveys List of Wholesalers Provided by DoJ Every 6 Months for Price Updates
- No Wholesaler Has Responded

DIR/DP

- Direct Price
- Provided by Manufacturer
- Price from Manufacturer to Non-wholesale Customers
- Least Populated of All Pricing Fields

Suggested Wholesale Price (SWP)

- Suggested Wholesale Price
- Provided by Manufacturer
- May or May Not Agree with Surveyed AWP
- May Be Higher or Lower than Surveyed AWP

manufacturers
~~- a lot, don't provide this any more~~

BaseLine Price (BLP)

- Statistical Analysis Applied to Calculate a Mean Average Price for Multi-source Products
- Must Be at Least 3 Active Generic Sources
- Based on Most Common Package Size
- Updated Monthly

Customized Pricing Fields

- FDB Will Work with Customers to Develop Custom Pricing Fields
- Algorithms
- MACs
- Additional Fees for Customized Fields

Orange Book Code

- Used in Conjunction with Formulary Development
- Reports FDA Orange Book Rating
- No Orange Book Rating, the Value is "Z" on NDDF
- Includes AB1, AB2 and AB3

↓
* to show did not forget
to populate field

Generic Classification Indicators

- Six Different Indicators
- Customized to Customer's Specifications
- Define Brand/Generic

Generic Indicator (GI)

- Differentiates Single-source from Multiple-source Drugs
- Based on GCN/GCNSEQNO
- Two Values Only
 - Single-source
 - Multiple-source

Generic Price Indicator (GPI)

- Distinguishes Products Based on Price
- Most Common Package Size is the Standard
- Products with Highest AWP = Brand
- Products with Lower AWP = Generic

Branded generic - standard duration

Haloperidol - 2 suppliers - generic

* 1 supplier of 10mg tablets left → single source now

Vietids - 2 suppliers left

- both same price (very low)

Generic Price Indicator (GPI)

- Excludes Non-drug Items
- Excludes Patent Protected/Cross-licensed Products
- Independent of:
 - Name
 - Innovator Status
 - Labeler

FDB can do algorithm to determine "generics"

Generic Price Indicator (GPI)

- Evaluated when AWP's change
- Very Dynamic
- Constant Review Necessary to Maintain Proper Values
- 4 Values

Generic Manufacturer Indicator (GMI)

Specifies Product by Manufacturer Strategy:

- Brand Manufacturer
- Generic Manufacturer
- Niche (Alternative) Manufacturer

Generic Therapeutic Drug Indicator (GTI)

Specifies product as:

- Innovator
- Orange Book "A" rated
- Orange Book "B" rated
- Product not listed in Orange Book

Orange Book codes

Generic Named Drug Indicator (GNI)

- Specifies Product as:
- Brand-named Product
 - Generic Name Only
 - Alternative Product

FDB
Generic
Indicator

Generic Spread Indicator (GSI)

- Specifies Product Based on Spread:
- Brand (< 25%)
 - Generic (= or > 25%)
 - Alternative (Generic Manufacturer and < 25%)
 - Spread Not Provided

Can use to flag generics

Innovator Indicator (INNOV)

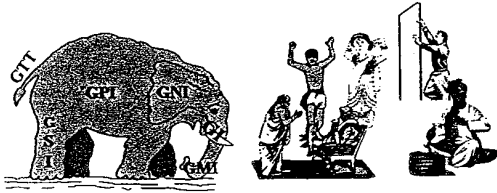
- Identifies the Original Product for a Particular Generic Code Number (GCN)
- Customer May Elect to Use in Conjunction with Formulary Development
- Many Plans Pay for Innovator

moving target now ^{brands} are dropping
out of the market

Summary

- Data – Each File Customized for Each Customer
- Many Options for Pricing
- Many Options for Brand/Generic
- Why Our Customers Have Questions

Brand/Generic Indicators



NOTES

AMP - CMS has the figure - not to be released to the states

Can request special file from FDB to see what funds available - not currently getting

FULS - based on WAC ($150\% \times WAC$) - from FDB

Markup going to $25\% \rightarrow 90\%$ now - waiting to finish - then ↑ discount from AMP

NOTES

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

NOTES

A series of horizontal lines for taking notes, spanning the width of the page below the 'NOTES' header. The lines are evenly spaced and cover the majority of the page area.

NOTES


This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

PATSY McELROY

**Standards Development Advisor
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Patsy McElroy is the Standards Development Advisor for the National Council for Prescription Drug Programs (NCPDP). Prior to joining the staff of the NCPDP last year, she was employed for twenty-five years by the Texas Department of Health Medicaid Prescription Drug Program as the Director of the Electronic Claims Management System.

Ms McElroy holds a BS Degree in Education and taught in the public school system for five years. At NCPDP, she serves as a business resource to the membership and public on the NCPDP Standards, provides liaison support to the Work Groups, and is responsible for the balloting process.




**NCPDP Telecommunication
Version 5.1**

Patsy McElroy
NCPDP
August 4, 2002



NCPDP the Organization

The National Council for Prescription Drug Programs (NCPDP) is an ANSI-accredited standards development organization representing the pharmacy industry. We are a membership driven organization that was named in HIPAA regulations.




**What NCPDP Documents Do
I Need for HIPAA?**

- Telecommunication Standard Version 5.1
 - Telecommunication Specifications
 - Telecommunications Implementation Guide
 - Data Dictionary of September 1999
 - Version 5 Editorial Document
 - Version 7.0 of May 2002
- Batch Standard Version 1.1
 - Batch Standard
 - Batch Implementation Guide

Presentation Title


1

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What Is The Purpose Of The Version 5 Editorial Document?

- Provides a consolidated reference point for clarifications
- Addresses editorial changes made to the
 - Telecommunication Specifications
 - Telecommunication Implementation Guide
 - Data Dictionary



Version 5 Changes

- Segments Added
 - Replaced the Sections
 - New Segments added by functionality
 - Data elements grouped into logical segments
 - Data elements sorted by order of importance within each segment



Version 5 Changes

- The Transaction Count field (109-A9) has replaced the embedded iterations in previous versions found in the Transaction Code (103-A3)
- The Transaction Count field will be present on every transaction request and response
- Old Transaction Codes deleted and new codes added

NCPDP

101-A1	Bin Number	01P000	
102-A2	Version/Release Number	31	5.1 Transaction Format
103-A3	Transaction Code	B1	Rx billing
104-A4	Processor Control Number	1234567890	
109-A9	Transaction Count	2	two occurrences
202-B2	Service Provider ID Qualifier	07	NCPDP Provider ID
201-B1	Service Provider ID	4563653200000000	
401-D1	Date of Service	1997/09/08	9/28/97
110-A1	Software Vendor/ Certification id	9876543210	

NCPDP

Version 5 Changes

- All of the \$ fields were increased in size
 - Old size maximum was \$9,999.99
 - New size maximum is \$999,999.99
- Change to Quantity fields
 - Only metric decimal quantity supported
 - Increased from 9(5)v999 to 9(7)v999
- Field Qualifiers were added
 - NDC Number x(12) changed to Product /Service ID x(19) with a qualifier

NCPDP

Counts

- A Count : Used to designate the number of repetitions to follow when a data field or a group of data fields can repeat and have a mandatory data field which appears at the beginning of each logical set/grouping

Example: Compound Segment

Count = 5 means that 5 ingredients will be reported (each begins with the Compound Product ID Qualifier Field)

Presentation Title

3

HI_HI 000002708



Multiple Transactions

- Transmissions Support One To Four Transactions
 - This includes Reversals
- Except
 - Eligibility, Prior Authorization, And Billing For Multiple Ingredients (Compounds)
 - These Transactions Only Allow One Transaction Per Transmission

4 transactions / transmission

4 records / "



Version 5.1 Enhancements

- True Service Claims
 - Claim can be submitted for service without having to have an associated Rx
 - Service Claim can refer to an Rx
- Enhanced Coordination of Benefits
 - Secondary/Tertiary can see primary reject codes
 - Secondary/Tertiary can see all primary payments (both Rx and Service Claims)

TPL

Cognitive service - does not have to be related to a prescription number




Version 5.1 Enhancements


- Expanded DUR Capability
 - Ability for Provider to respond to multiple alerts (Reason for Service Codes) in one transaction
 - Ability for Providers to send PPS codes and supporting info on the claim
- Partial Fill Capability
 - Pharmacy can report the dispensing of an initial partial fill and in a separate transaction report the dispensing of the remaining quantity without
 - Additional dispensing fee
 - Additional refill number
 - False DUR warnings

Rx can do the partial fill - what actually filled + then bill remainder *

No fee paid - front or back end?




**Where Do I Find Answers
To Questions About
NCPDP
Telecommunication
Specifications Version 5?**




**What Transactions Are Supported
And For What Business
Purposes?**

- Specifications
 - Transaction Discussion
 - Section 6
 - Transaction Types
 - Section 7
- Implementation Guide
 - Special Considerations - Transactions, Segments, and Fields
 - Section 4




What Fields Changed?

- Data Dictionary
 - Old Field Name Cross Reference
 - Section V
 - New Field Name Cross Reference
 - Section VI
 - Deleted Data Elements Not Supported in Version 5
 - Section VII of Data Dictionary

 **NCPDP**


Which Fields Are Allowed In Which Segments?

- Implementation Guide
 - Request and Response Quick Reference
 - Section 5 of Implementation

 **NCPDP**


Where Do The Segments Belong?

- Implementation Guide
 - Segment Usage Matrix
 - Section 3
- Specifications
 - Transmission Request Diagrams
 - Section 10
 - Transmission Response Diagrams
 - Section 12


 **NCPDP**

What Are The Valid Responses For Each Transmission?

- Specifications
 - Transmission Response Discussion
 - Section 11
- Implementation Guide
 - Response Segment Matrices
 - Section 3
 - Response Transactions
 - Section 4
- Version 5 Editorial
 - Response Segment Discussion


 **Count Fields – Diagrammed
Compound Segment**

*Segment Identification	10
~Compound Ingrid. Component Count	2
>Compound Prod Id Qualifier	03
>Compound Prod. ID	00005000401
>Compound Ingrid. Quantity	30
>Compound Ingrid. Drug Cost	45.11
>Compound Prod Id Qualifier	03
>Compound Prod. ID	00005000651
>Compound Ingrid. Quantity	02
>Compound Ingrid. Drug Cost	19.78


 **Counter Fields**

- Counter: Used to designate the repetition number when a group of fields repeat and do not have mandatory data fields which can delineate the beginning of a new logical set/grouping


Example: DUR/PPS Segment
DUR/PPS Code Counter = 1 (to designate the 1st occurrence within the segment)
DUR/PPS Code Counter = 2 (to designate the 2nd occurrence within the segment)

 **Counter Fields – Diagrammed
DUR/PPS Segment**


*Segment Identification	08
~DUR/PPS Code Counter	1
> Reason for Service Code	PS
>Professional Service Code	DE
>Result of Service Code	1K
~ DUR/PPS Code Counter	2
>DUR Co-Agent ID Qualifier	03
>DUR Co-Agent ID	0005000401

 **Recommended Use Of Dollar Fields And Calculated Amounts**


- **Implementation Guide**
 - Special Considerations - Transactions, Segments, and Fields
 - Section 4
 - Frequently Asked Questions
 - Section 8
- **Version 5 Editorial**
 - Request Segment Discussion
 - Pricing Segment
 - Response Segment Discussion
 - Response Pricing Segment
 - Pricing Guidelines

 **Explain The Syntax Rules For Version 5**


- **Specifications**
 - Document Conventions
 - Section 8
- **Implementation Guide**
 - Generally Accepted and Common Practices
 - Section 2
- **Version 5 Editorial**
 - Transmission/Transaction Syntax

 **What Has Changed In Version 5.2, 5.3, et cetera?**

- **Specifications**
 - Appendix A
 - Section 13
- **Implementation Guide**
 - Version Changes
 - Section 9
- **Data Dictionary**
 - Version Modifications
 - Section M




**Privacy Regulations
Telecommunication 5.1 and
Batch 1.1**



**Privacy Regulations – Response to
Commenter Page 82617**

Response: We make an exception to the minimum necessary disclosure provision of this rule for the required and situational data elements of the standard transactions adopted in the Transactions Rule, because those elements were agreed to through the ANSI-accredited consensus development process. The minimum necessary requirements do apply to optional elements in such standard transactions, because industry consensus has not resulted in precise and unambiguous situation specific language to describe their usage. This is particularly relevant to the NCPDP standards for retail pharmacy transactions referenced by these commenters, in which the current standard leaves most fields optional.



**Privacy Regulations - Standards for
Electronic Transactions Page 82545**

We clarify that under Sec. 164.502(b)(2)(v), covered entities are not required to apply the minimum necessary standard to the required or situational data elements specified in the implementation guides for HIPAA administrative simplification standard transactions in the Transactions Rule. The standard does apply for uses or disclosures in standard transactions that are made at the option of the covered entity.

Presentation Title



What Were The Next Steps After the Privacy Regulations Were Released?

- Optional fields do not show industry consensus - rectify
- Could not "add" to the Version 5 documents
- Therefore, creation of a Protocol document

"Consensus"



What Is The Protocol Document?

- Each transaction supported in Version 5.1 (or Batch 1.1) is defined by segments and fields
- Each segment and field that was defined as "optional" has been changed to "situational" with situations defined for the usage
- The document supports HIPAA named and NON HIPAA named transactions – the document is for any implementation of Version 5.1 or Batch 1.1



Why Is The Protocol Document Important?

- For the HIPAA named transactions, to become exempt from the minimum necessary requirements, situations must be defined for segments and fields
- For the HIPAA named transactions, once the situations are established, if they are not followed, this will be a violation of the transaction set final rule and penalties will be established in a separate Enforcement Final Rule
- Pharmacy industry participants must verify their business cases are reflected in the situations defined, otherwise they will be unable to use the field/segment for purposes not covered under the situation



How Is The Protocol Document Used?

- First, apply the situations to the segments and fields
- Second, apply the privacy regulations against the Protocol document – if the field/segment is used in the situation named, the minimum necessary rules do not apply
- (Do not apply the Privacy regulations to the fields and segments first, then apply the situations.)

Example: fields needed + defined.
incentive on success - restock "incentive"
fee on the response



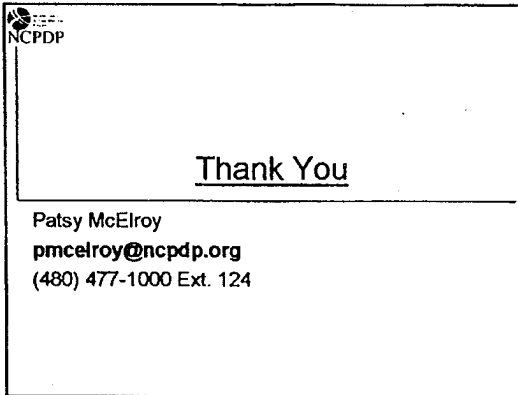
Next Steps (Near Term)

- Continue to review/revise/create the situations for the segments and fields
- Ballot the Protocol document via NCPDP's consensus process
- Submit the document via an FAQ to the Office of Civil Rights to be recognized as meeting the minimum necessary requirements
- Submit a request to the Designated Standards Maintenance Organization (DSMO) Change Request System (CRS)



Next Steps (Long Term)

- Incorporate the Protocol document information into a next version of the Telecommunication and Batch Standard
- Ballot the next version of the Standards
- When appropriate, submit the next version of the Telecommunication and Batch Standards through the Designated Standards Maintenance Organization (DSMO) Change Request System (CRS) for inclusion in the next versions named by Transactions and Code Sets regulations



Presentation Title

12

HI_HI 000002717

NOTES

PA's - NEPPP - accommodate clinically based PA
- submit PA request electronically + then for the
- PA form over

NOTES

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NOTES

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Price Control Laws for
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State and Federal Confidentiality
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Ms. Boswell is a partner in the Health Group, resident in the Washington, D.C. office of Hogan & Hartson L.L.P. Her practice focuses on providing strategic advice to research companies, health Internet companies, and manufacturers of new technologies concerning compliance with the federal pharmaceutical pricing and rebate statutes, federal and state confidentiality laws, and the business impact of government and private payers' coverage, coding, and reimbursement systems. She also has represented clients' interests in administrative proceedings before various agencies, has drafted comprehensive legislation as well as amendments of existing laws for groups of providers, physicians and manufacturers, and has spoken to legal, business and government personnel concerning the federal pharmaceutical pricing statutes and confidentiality legislation as well as health care, Medicaid, and Medicare reform legislation.

Before joining Hogan and Hartson, Ms. Boswell was a college professor at Wesleyan University, teaching psychology and philosophy of science. She also served as a legislative assistant in the United States Senate as a Congressional Fellow of the American Association for the Advancement of Science and the Society for Research in Child Development. Ms. Boswell received her undergraduate training at Wake Forest University and earned her Ph.D. in psychology from Pennsylvania State University. She received her J.D. from the University of Pennsylvania where she served as executive Editor to the Law Review.

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Publications: Boswell, Donna and Marcy Wilder. "HIPPA and the Federal Privacy Standards for Health Information." *Hogan & Hartson LLP Focus on Medical Privacy* (June 2001).

NOTESHouse Passed Medicare Drug Benefit

"Actuarially equivalent" benefit designed by PDPs + MA-C plans

Beneficiary Cost-sharing

WAC - 2%

- \$35 / month premium

- \$250 deductible / year

- 80% of first \$1000 after deductible

50% of next \$1000 (which is \$950)

- copay capped for "low-income" (< 200%) at \$2.00 for

multiple sources; \$5 for non-preferred

- after beneficiary spends \$3,800 out-of-pocket (ad plan-discount ratio)

Senate - defeated 4 bills

Reimportation from Canada	} legislation
Patents for Brands - addressed	

Cost of Care

Medicaid - 18%

Medicare - 17%

Out of pocket - 15%

Private Insur - 34%

Other Public - 12%

Other Public = 5

Consumers = 15% Breakdown

Hospitals 3.15%

MDs & clinics - 12%

Nursing home + home health - 25%

→ Rx drugs - (32%)

State + Local funding

Hosp 12%

MDs - 6%

LTC + Home Health - 18%

→ Drugs - 9.27%

Pharmacy Plus Program - "Budget Neutral" - will not work for states

NOTES

PhRMA Sinit

- Do not use medicaid beneficiaries as hostages in your budget battle

① Pay cms rebates

② Pay supplemental rebates or will burden medicaid recipient access

③ Pay rebates + will favor your drug

Alternatives for Managing Outlay of Prescription

① Use PAs -

target hi cost cases

- manage clinical + non-clinical needs of chronic dx
- tackle drugs where OUC has shown misuse

out of cms rebates →

② Negotiate rebates for specific drugs to meet of pat population
cms should allow States to negotiate own rates

③ If you create formularies or preferred drug list for medicaid, follow the law

④ Financial incentives for beneficiary cost-sharing ^{follow the law.}
^{the law}Pharmacy Plus - convert seniors into ^{medicaid} waiver program

→ "budget neutral" issue

- Can we include "allowings" (from Medicare shifts in services (?))
- Fed match (regular) rate

Terry + Florida - opting out - asked but Secretary denied

Secretary can allow the state to negotiate "instead of" with manufacturers

- ~~must~~ share match with CMS + States will still get FFP
(rebates)

NOTES

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*14yoa daughter
started high school
plays violin 1/5/02
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pg. 1

8/2/02



THE RITZ-CARLTON®

Utah

Highest use clients - School of Pharmacy review \$ 289,000 /yr

- 200 reviews / year
- prescribers → did not see patient etc, prescribe ^{these}
- do face-to-face with prescribers

Texas - signed Heritage Info Systems
 Martha ↓

prescribers access patient drug profiles via Internet

Lori - Georgia

- certain therapeutic categories → retrospective mailout of Rx profiles to MDs

Siri - WA

- prescribers can call ACS clinical Rxs to get profiles → part of

Therapeutic Consultation Service

3 ways: fax, email, regular mail - prescriber can request profile

Contract w/ Hippocrates → info available via palm pilot

Mass - Paul

- pharmacy chains pulling out → Rx recomb: ^{WAC} ~~2%~~ - 2% + \$3.00 disp. fee
 Walgreens, Brooks (50% ^{dropped})
 CVS (threatened to pull out)
 ↓
 nothing official yet
- Rate not changed right away → cheating (emergency)

pg 2



THE RITZ-CARLTON®

8/2/02

- both Rx + LTCs to pay tax

→ can get FPP

- user tax → would help pay dispensing fees - non Medicaid/Rx → with Medicare pass on cost to customer
- Medicaid Copay = \$200 (from \$50)
- Pharmaceutical lobby → how Medicaid save \$ → reduce rate to pharmacies
- Preferred drug list → implemented yesterday

Florida → showed savings with asthma OSM program
 - (ER) maints, hospitalization

- most companies know can't show "value added" savings → BMS wrote a check right up front
- others think can save ~~on~~ after second year → don't think will actually reach designated goals → medication compliance, ER use, med errors

Maryland:

- Outpatient hospital - disproportionate share hospital → should charge cost of drug (340B) → revenue code - don't know what drugs UB92
- offering to pay back Medicaid \$100,000/yr.

Utah

- have 10 - 340B providers
- supposed to bill cost
- bill Medicaid ratio - but take away AWP - 31%
31% off
 (AWP - 12%) Subtract another 19% off payment

- "means test" to be 340B provider
- pricing changes during the contract period →

quality
340B pricing

Mass-

- carve out drugs or lower capitation rate → lower drug costs
- 2 plans - 340B entities → disproportionate share

Pg. 3

8/2/02



THE RITZ-CARLTON®

Jocobs → Delaware

NDC

single source → Roma in Wisconsin

FDB → each qtr go back - look at % of claims -

DataNiche - do we ~~get~~ give them the Rx number?HIPAA

Apples - 837

~~Insulin~~ - NCPDP 5.1

} maybe able to switch around?

Roma, Wisconsin

lockin program → saved a lot of \$

- both pharm + MD lock in

- show reduction ~~in~~ overall

Pay pharmacy monthly fee for lock in - presently pay MD

want (Shannon) - Wyoming

Pharmacy case manager - Pharmacist → to manage lockin program

Oregon - evidence based ^{preferred} drug list on the Internet + NSAIDSAHRQ

- federally funded, nationally accredited

- pharmacoeconomic evaluation

- Should pay more for a certain drug or not?

- sometimes - no evidence to choose 1 product over another

- working on next 5 classes:

ACEI

- not sponsored by pharm. industry

* - meeting sponsored in Oregon in Oct → Drug Costs

pg. 4



THE RITZ-CARLTON®

New York

Prescription drug telephone PA - prompted → if okay → PA number
given → put on Kx so claim can process
Assistim + A rated Brembo - 6 (original + 5 refills)
↓
one at a time

Siri - WA

- ~~lower~~ lowers the 4 brand limit / stored a lot of money.
a lot of ~~in~~ inappropriate use - drugs below the radar



THE RITZ-CARLTON®

pg #1

8/5/02

#1

Roma - Wisconsin

- going to Taiwan - vacation
- + Nagano - Husband, Bob, publisher trip - she's tag along university professor
- after meeting - visiting with her son + grand daughter for a few days

Dave - Alaska

- wife going to NMPAA
- used to have red hair (just a red beard now)

Caroline - South Carolina

has Smacs - how determined?

- 14 year daughter - "prone to fainting spells"
- fell around May this year - cut lip severely + dislodged several teeth
- beginner's permit around Dec this year
- just remodeled house - extensive termite damage
- husband is 15 years older
- used to own her own pharmacy
- native S. Carolina - has family there
- brother-in-law is a dentist
- treasurer of NMPAA (AMPAA)
- doesn't drink wine
- First Health - claims + rebates (doing as well as can be expected)



THE RITZ-CARLTON®

pg # 2

8/5/02

Susan - Wyoming

- Shannon's Pharmacy Data Analyst
- She Shannon planned NMPPA meeting - meals, she picked the chocolate covered strawberries
- had breakfast with them Friday morning at the hotel

Benny Ridgeway - (was N. Carolina)

- retired in Dec. last year
- consultant for several drug companies now
- raised \$ for the NMPPA ~~meeting~~
- involved with autistic children - had met with Israeli prime minister Rabin (was assassinated a month later)

Joe - Maryland

- car accident happened last semester of pharmacy school - spinal cord injury (mid 1970's)
- wife divorced him shortly after accident - took 5 month old daughter + moved to Walnut Creek, CA (felt strange being so close after all these years)
- is Jewish - attends synagogue
- has been with Maryland Medicaid - 30 years
- his daughter contacted him a few months ago - lives in Maryland now + has reunited; has a granddaughter - scared to ride with him in his wheel chair yet - runs alongside
- NMPPA meeting a religious time for him but going anyway



THE RITZ-CARLTON®

pg #3

8/5/02

- not good with paperwork - better at being a manager
- responsible for TPL statewide
- has staff to handle every day stuff
- loves to read books - has a book prop so can eat + read
- has own condo, takes the train - gets around whenever
- reads a book a week
- loves movies too - saw Windtalkers, Pearl Harbor

Jerry Wells - Florida

- lives on Gulf of Mexico - 165 ft of waterfront - rents out boat slips - covers his taxes
- divorced then remarried → each had 2 kids - built new house on the property - didn't buy any ^{more} ~~more~~ lots - too bad (lot next door over \$200,000 ^{can't afford it now})
- sold ~~some~~ his rental properties this year - looking for some tax shelter

Peggy - W. Virginia

- ~~beat~~ brought a "healthy back" purse in Napa Valley - Yountsville
- bought an "oilt vinegar" decanter at Rutherford Hill Winery - likely her daughter will end up with it
- works with "Vicky"
- contract out for bid - will ACS work?

pg #4

8/5/02



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Neal- New Mexico

- wife - Wanda - nurse - does screening of 6 different problems
 ^{native american}
 on children - like PKU, thyroid Navajo from CA
- ^{Wanda} would like to work with CDC - ~~bio terrorism~~ bio terrorism
- Wanda will beat WMPAA
- celebrated her birthday (?) in Chenatown during NMPAA
- sent Pena Nuts to me + Kathleen
- live ~~outside~~ Santa Fe
- Omnicoid a mess right now (ACS mmis); PDCs going okay

Peggy - New Hampshire

- have First Health - really like pharmaco economic ^(pittsburgh) ~~per~~ ACS)
- presentation → guy died → have assigned some others
- use Delaware [I think] for Trade crosswalk
- husband ~~is~~ Don - a contractor
- own a duplex with another couple and have own house

pg #5

Martha - Texas

- daughter works for PR firm in CA (San Francisco area?)
 - her fiancée moved there + then she accepted a job there recently
 - her son + daughter-in-law just finished an extended honeymoon in Italy → really liked it here - fit right in + accepted her son as their own
 - she is an attorney who flies all over + her son jumps on a plane + joins her wherever/whenever he can
-

Raedelle - Utah

- she + her sister do a lot together
 - her son - has a long distance relationship (married?) with a lady in Paris. He visits several times during the year.
-